

CUSTOMER SERVICE FORM

Purpose: This form is to be used by Local Management Entity/ Managed Care Organization (LME/MCO) staff to document customer service issues such as concerns, complaints, compliments, investigations and requests for information involving any person requesting or receiving publicly funded MH/DD/SA services from a LME/MCO or a MH/DD/SAS provider.

Tracking #: _____

Person reporting customer service issue:

Date: _____

Name: _____ Phone: H: _____ W: _____ C: _____

Address: _____

Person reporting customer service issue is:

☐ Anonymous ☐ Attorney ☐ Client ☐ Client advocate/representative ☐ DMH/DD/SAS staff ☐ Family member
☐ Parent/Guardian ☐ DMA ☐ LME/MCO Staff ☐ Provider ☐ Other (specify): _____

If customer service issue involves a client:

Client name: _____ Phone: H: _____ W: _____ C: _____

Address: _____

DOB: _____ Age: _____ Gender: ☐ Male ☐ Female Disability (check all that apply): ☐ MH ☐ DD ☐ SA ☐ UNK ☐ N/A

County of Services: _____ Medicaid County: _____ Home LME/MCO: _____ Host LME/MCO: _____

Race/Ethnicity: ☐ Hispanic/ Latino ☐ African American ☐ Caucasian ☐ Native Indian ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Multi-racial ☐ Unknown ☐ Other

Parent/Guardian: _____ Phone: H: _____ W: _____ C: _____

Address: _____

Funding Source(s): ☐ County Funds ☐ Health Choice ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ State Funds ☐ Self-Pay

Customer service issue was received via:

☐ Call ☐ Customer Service Form ☐ Email ☐ Fax ☐ In Person ☐ Website ☐ Written Correspondence
☐ DMA Quality of Care

If issue was referred to the LME/MCO, indicate referral source and specify which LME/MCO or office:

☐ Another LME/MCO ☐ County Office ☐ Provider's Office ☐ DMH/DD/SAS ☐ DMA ☐ DHSR ☐ Other
(Specify): _____

Type of Case: ☐ Complaint/Concern ☐ Compliment ☐ Information/Referral ☐ Investigation **Priority:** ☐ Routine ☐ High

Nature of primary customer service issue. Issue is related to: (Check only 1 Primary Issue)

☐ Abuse, Neglect, Exploitation ☐ Basic Needs ☐ Provider Choice
☐ Access to Services ☐ Client Rights ☐ Quality of Services
☐ Administrative Issues ☐ Confidentiality/HIPAA ☐ Service Coordination Between Providers
☐ Authorization/ Payment/Billing ☐ LME/MCO Functions ☐ Other (specify): _____

Customer service issue notes: (Attach additional pages if needed)

If customer service issue is about a provider or agency:**Provider Category:** ☐ A ☐ B ☐ C ☐ D

Provider/agency name: _____ Phone: _____ Fax: _____

Address: _____

Type/Level of Service: (Check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Adult Day Vocational Program | <input type="checkbox"/> IDD Care Coordination | <input type="checkbox"/> Outpatient Services | <input type="checkbox"/> SA Intensive Outpatient |
| <input type="checkbox"/> Ambulatory Detoxification | <input type="checkbox"/> IDD Targeted Case Management | <input type="checkbox"/> Partial Hospitalization | <input type="checkbox"/> SA Comprehensive Outpt. Tx |
| <input type="checkbox"/> Assertive Community Tx Team | <input type="checkbox"/> Intensive In-Home Services | <input type="checkbox"/> Peer Support Services | <input type="checkbox"/> SA Non-Medical Community Residential Tx |
| <input type="checkbox"/> Child & Adolescent Day Tx | <input type="checkbox"/> Mobile Crisis Management | <input type="checkbox"/> Peer Support Service (B3-Only) | <input type="checkbox"/> SA Medically Monitored Community Residential Tx |
| <input type="checkbox"/> Clinical Intake | <input type="checkbox"/> Medically Supervised or ADATC Detox/Crisis Stabilization | <input type="checkbox"/> Psychosocial Rehabilitation | <input type="checkbox"/> SA Halfway House |
| <input type="checkbox"/> Community Guide (MCO) | <input type="checkbox"/> Medication Administration | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Social Setting Detoxification |
| <input type="checkbox"/> Community Support Team | <input type="checkbox"/> MH/SA Care Coordination | <input type="checkbox"/> Psychiatric Services | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Community Alternatives Program | <input type="checkbox"/> MH/ SA Targeted Case Mgmt | <input type="checkbox"/> Residential Services (Category) | <input type="checkbox"/> Not Service Related |
| <input type="checkbox"/> Crisis Services | <input type="checkbox"/> Multisystemic Therapy (MST) | <input type="checkbox"/> Respite (MCO B3 Only) | <input type="checkbox"/> Unknown/ Not Known |
| <input type="checkbox"/> Developmental Therapies | <input type="checkbox"/> Non-Hospital Medical Detox | <input type="checkbox"/> Respite | |
| <input type="checkbox"/> Diagnostic Assessment | <input type="checkbox"/> Opioid Treatment | <input type="checkbox"/> Screening, Triage and Referral | |
| <input type="checkbox"/> Drop-In Center | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Sheltered Workshop | |
| <input type="checkbox"/> Facility-Based Crisis Program | | | |

Is the Provider Licensed? ☐ Yes ☐ NoLicensing Agency: ☐ DHSR ☐ DSS**Residential****Is Residential an issue in the complaint?** ☐ Yes ☐ No**Was consumer involved in DOJ issue?** ☐ Yes ☐ No**Residential Location:** ☐ In-State ☐ Out-of-State within 40 mile radius ☐ Out of State outside of 40 mile radius**Residential Type:**

- | | | |
|---|--|--|
| <input type="checkbox"/> Own home | <input type="checkbox"/> Parents'/ Guardian's Home | <input type="checkbox"/> PRTF |
| <input type="checkbox"/> Therapeutic Foster Care | | <input type="checkbox"/> Level III |
| <input type="checkbox"/> Supervised Living A (Adult with Mental Health Concerns) | | <input type="checkbox"/> Family Care Home |
| <input type="checkbox"/> Supervised Living 5600 B (Minor with Intellectual/Developmental Disabilities) | | <input type="checkbox"/> MH Apartment - Supervised |
| <input type="checkbox"/> Supervised Living 5600 C (Adult with Intellectual /Developmental Disabilities) | | <input type="checkbox"/> Level IV |
| <input type="checkbox"/> Supervised Living 5600 D (Minor with Substance Abuse Concerns) | | <input type="checkbox"/> SA Halfway House |
| <input type="checkbox"/> Supervised Living 5600 E (Adult with Substance Abuse Concerns) | | <input type="checkbox"/> Other |
| <input type="checkbox"/> Supervised Living 5600 F (Alternative Family Living) | | <input type="checkbox"/> No Residential Services |

Did the person discuss the issue with the provider/agency? ☐ Yes ☐ NoDid the person give permission to use his/her name during discussion about this issue with the provider/agency? ☐ Yes ☐ No**Action taken by LME/MCO:**

- ☐ Shared the customer service issue with the provider/agency/person(s) involved.
- ☐ Provided the information requested.
- ☐ Facilitated informal discussion/resolution with the provider/agency involved.
- ☐ Facilitated informal discussion/resolution within the LME/MCO.
- ☐ Provided information on how to initiate a Medicaid appeal or LME/MCO complaint process.
- ☐ Conducted Investigation. Person(s) investigating concern: _____
- Concern was: ☐ Substantiated ☐ Partially Substantiated ☐ Not Substantiated.
- Based on findings: ☐ No further action needed ☐ Recommendations provided ☐ Corrective Action Plan required
- Date report of findings issued: _____ Number of days from date received until report of findings issued: _____
- Date Plan was received: _____ Plan was: ☐ Accepted ☐ Returned For Revision
- Date Plan was resubmitted: _____ Resubmitted Plan was: ☐ Accepted ☐ Not Accepted
- Date of Follow-up review: _____ Corrective actions were: ☐ Successful ☐ Unsuccessful
- ☐ Referred to: ☐ DHSR ☐ DMH/DD/SAS ☐ DMA ☐ DSS ☐ Other (Specify) _____ Date: _____
- For: ☐ information ☐ action (specify): _____

Summary Of Issue(s), Investigation, and Actions Taken *(Include dates) (Attach additional pages if needed):*

Final Disposition: [Action(s) taken include dates]

Resolution

Issue(s) was(were): ☐ Resolved/Completed ☐ Partially Resolved ☐ Unresolved

Resolved by: ☐ LME/MCO ☐ DHSR ☐ DMH/DD/SAS ☐ DSS ☐ DMA (includes Program Integrity)

Outcome of Complaints that were NOT Investigated:

- ☐ Information or technical assistance was provided to complainant
- ☐ Worked with Provider for Resolution
- ☐ Referred to Community Resource or Advocacy Group
- ☐ Referred to External Licensing or State Agency
- ☐ Referred to Another LME/MCO for resolution
- ☐ Mediation with parties

Resolution was Appealed:

- ☐ N/A
- ☐ 2nd Level Review to Client Rights Committee
- ☐ 2nd Level Review to LME/MCO Director
- ☐ Provider Appeal Panel

Number of **Calendar Days** from Receipt to Completion: _____

Number of **Working Days** from Receipt to Completion: _____

Date Resolved: _____

Written feedback of final disposition/resolution was provided to:

Person completing this form:

Date: